STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING 00 B. WING	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of complaint number IN00100584. Complaint IN00100584 substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226. Survey date: December 7, 8, 9, 12, 13, 2011 Facility number: 000195 Provider number: 155298 AIM number: 100267690 Survey team: Charles Stevenson RN Census bed type: SNF/ NF: 88 Total: 88 Census payor type: Medicare: 11 Medicaid: 64 Other: 13 Total: 88 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 12/15/11 Cathy Emswiller RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to protect residents from potential verbal abuse for residents involved in a group activity and failed to protect a resident (Resident B) after an	F0225	Element #1: It is the policy of theis facility to see that any allegation of abuse or any actual abuse is thoroughly investigated, immediately reported to the administrator and reported to the	01/12/2012

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	allegation of sexually inappropriate behavior by a facility visitor by not thoroughly investigating and reporting to the State Agency as required by State law and facility policy for 1 of 3 residents reviewed for investigation and reporting of allegations of abuse. (Resident B) Findings include: The record of Resident B was reviewed on 12/09/11 at 10:00 a.m. Diagnoses included, but were not limited to, sickle cell disease, seizure disorder, hepatitis C, chronic leukocytosis, and anxiety. During an interview on 12/12/11 at 9:45 a.m. with the 3rd floor Unit Manager/Assistant Director of Nursing (ADON) she indicated that on Sunday 10/23/11 she received a phone call from a nurse on the 3rd floor indicating an allegation had been made that a male visitor had been in a female resident's room (Resident B) while the resident was partially unclothed. The ADON indicated that she then came to the facility, investigated the incident, and prepared a report of her findings. The ADON indicated she placed her report in a sealed envelope and put it in the mail box of the Director of Nursing (DON). The ADON		state agency (ISDH). Further, any residents involved is to be protected immediately from any further abuse or further potential abuse. Additionally, all threats are to be immediately removed from the facility. This includes any person who may be suspected of alleged abuse. All residents in group settings as well as resident B are protected and kept safe at all times. Plus, all residents involved in any incident of abuse or alleged abuse will have that incident thorougly and completely investigated and reported to all appropriate parties as stated in the facility policy and per regulation set forth by the state and federal agencies. Activity aide #1 has been counseled and educated as to their parameter as far as acceptable language and behaviors to be used with residents. Element #2: All residents have the potential to be affected by this finding. The administrator interviewed the resident s in the afore mentioned "group" that had been led by activity aide #1 to see if any residents had been offended. None had. Resident B was reminded to keep her door shut when she is not completely dressed as passersby could glance in her room and see her. (This behavior is and was on her careplan). Going forward, all incidents of abuse or potential abuse will be immediately	

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	also indicated that on 10/24/11 she was asked by the Director of Operations (DO) to retrieve her report of the incident from the DON and give it to her (the DO). The ADON indicated she did this. During an interview with the DON on 12/12/11 at 11:00 a.m. the DON indicated she had retrieved a sealed envelope from the ADON from her mail box on 10/24/11. She indicated that before she could read it, the ADON retrieved it from her, indicated that she had been instructed that only the DO was to have copies of her investigation. An untitled documented dated 10/23/11 and signed as prepared by the ADON and identified as her report of the incident of 10/23/11 involving Resident B included, but was not limited to: "The writer received a phone call from...the nurse on the 3rd floor that there was a preacher in the building and that he went into a resident's room that wasn't dressed. (Activity Aide #1) brought the res (Resident B) to the nurses station and ...seemed mad and told the res to tell nurses what happened and res stated 'I told him to get the h--- out of my room and he didn't and then I told him again.' Then (Activity Aide #1) stated he checked and that the preacher wasn't even		reported to the adminsitrator and the policy and procedure as stated prior will be followed as far as safety, assessment, investigation and reporting to all proper parties will be followed. Element #3: At an all staff inservice held 1/10/2012 the policy and procedure for abuse will be covered including: 1. Abuse Policy 2. Types of abuse 3. Step by step action to be taken if abuse is suspected. 4. Questiions/answers/discussion Any staff who fail to comply with the points of the inservice will be further disciplined as appropriate, up to and including termination. Element #4: At the monthly QA meetings, any reports of abuse or alleged abuse will be reviewed to be certain all proper protocols were followed including, but not limited to: 1. Providing immediate safety for residents 2. Removing threat/assessing resident 3. Reporting to the adminisrator 4. Complete investigation/interviews 5. All proper reporting to all appropriate parties. Any concerns will be immediately addressed by the administrator.	

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	supposed to be in the building until 6:30 p.m. The nurse also reported that the aides from the second floor were here saying...that (Activity Aide #1) was going all over the bldg (building) telling people and now it was going to be reported to the state. (CNA #4) phoned this writer and stated that the preacher was in the hall...she asked the nurse who the resident was...she stated it was (Resident B)...then she went to the door...and noticed she (Resident B) had only a shirt on..." A "Notice of Disciplinary Action: dated 10/23/11 and signed as completed by ADON #3 for Activity Aide #1 included, but was not limited to: "Employee's Name: (Activity Aide #1)... Reported AA (Activity Aide) brought resident to nrsg (nursing) station et (and) had her report 'Man in her rm (room) et she told him to get the h--- out X2 (twice). (Activity Aide #1) responded with 'I checked the schedule he's not supposed to be in her till 6:30...(Activity Aide #1) then to 2nd floor stating it would be a reportable to state..." During an interview with the Administrator on 12/07/11 at 3:00 p.m. he			

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	indicated Activity Aide #1 "walks a fine line" about discussing inappropriate material in groups including female residents and that he sometimes has to "reign him in." He also indicated that "sometime recently" (date uncertain) that LPN #5 had reported to him what she believed was an incident of resident verbal abuse. She indicated Activity Aide #1 was leading an activity group in the 3rd floor dining with approximately 10 residents in attendance, "mostly female" and that some topics discussed, including homosexuality and related activities, may have been inappropriate and potentially distressing to some residents present. LPN #5 was interviewed on 12/07/11 at 3:20 p.m. She indicated that she had been working at the 3rd floor nurse's station and heard Activity Aide #1 leading a group discussion, and that the topics of discussion were in her opinion inappropriate, including homosexuality and sexual activities. She indicated she was concerned that some topics of discussion may have been offensive or threatening to some residents present and that they may have had fear or anxiety as a result. She also indicated she had presented her concerns directly to the Administrator on the day it occurred but that she had not been advised of any follow up investigation or interventions.			

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	A facility "Notice of Disciplinary Action" dated 10/07/11 for Activity Aide #1 indicated "...Inappropriate material, shared with others. Questionable topic covered in group discussions." During an interview with the Administrator on 12/12/11 at 2:40 p.m. he indicated that the above incidents had been reported to him as documented. He indicated he gave consideration to each incident, and decided the allegations did not merit reporting to the State Agency. He also indicated he had investigated the incidents, but had no documentation of any investigation, including but not limited to identifying potentially affected residents, interviewing residents to determine if Activity Aide #1 had a history of verbal abuse or other concerns, or interviewing staff members to establish if there was a pattern of verbally abusive behavior by Activity Aide #1. He also indicated that the incident of 10/23/11 involving Resident B had not been reported to the State Agency and that he had not done a formal, documented investigation to determine if there was any potential risk to residents based on the allegations of this event. 3.1-28(c)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to protect residents from potential verbal abuse for residents involved in a group activity and failed to protect a resident (Resident B) after an allegation of sexually inappropriate behavior by a facility visitor by not thoroughly investigating and reporting to the State Agency as required by State law and facility policy for 1 of 3 residents reviewed for investigation and reporting of allegations of abuse. (Resident B) Findings include: 1. The record of Resident B was reviewed on 12/09/11 at 10:00 a.m. Diagnoses included, but were not limited to, sickle cell disease, seizure disorder, hepatitis C, chronic leukocytosis, and anxiety. During an interview on 12/12/11 at 9:45 a.m. with the 3rd floor Unit Manager/Assistant Director of Nursing	F0226	Element #1: It is the policy of theis facility to see that any allegation of abuse or any actual abuse is thoroughly investigated, immediately reported to the administrator and reported to the state agency (ISDH). Further, any residents involved is to be protected immediately from any further abuse or further potential abuse. Additionally, all threats are to be immediately removed from the facility. This includes any person who may be suspected of alleged abuse. All residents in group settings as well as resident B are protected and kept safe at all times. Plus, all residents involved in any incident of abuse or alleged abuse will have that incident thorougly and completely investigated and reported to all appropriate parties as stated in the facility policy and per regulation set forth by the state and federal agencies. Activity aide #1 has been counseled and educated as to their parameter as far as acceptable language and behaviors to be used with residents. Element #2: All residents have the potential to be affected by this finding. The	01/12/2012

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	(ADON) she indicated that on Sunday 10/23/11 she received a phone call from a nurse on the 3rd floor indicating an allegation had been made that a male visitor had been in a female resident's room (Resident B) while the resident was partially unclothed. The ADON indicated that she then came to the facility, investigated the incident, and prepared a report of her findings. The ADON indicated she placed her report in a sealed envelope and put it in the mail box of the Director of Nursing (DON). The ADON also indicated that on 10/24/11 she was asked by the Director of Operations (DO) to retrieve her report of the incident from the DON and give it to her (the DO). The ADON indicated she did this. During an interview with the DON on 12/12/11 at 11:00 a.m. the DON indicated she had retrieved a sealed envelope from the ADON from her mail box on 10/24/11. She indicated that before she could read it, the ADON retrieved it from her, indicated that she had been instructed that only the DO was to have copies of her investigation. An untitled documented dated 10/23/11 and signed as prepared by the ADON and identified as her report of the incident of 10/23/11 involving Resident B included, but was not limited to:		administrator interviewed the resident s in the afore mentioned "group" that had been led by activity aide #1 to see if any residents had been offended. None had. Resident B was reminded to keep her door shut when she is not completely dressed as passersby could glance in her room and see her. (This behavior is and was on her careplan). Going forward, all incidents of abuse or potential abuse will be immediately reported to the adminsitrator and the policy and procedure as stated prior will be followed as far as safety, assessment, investigation and reporting to all proper parties will be followed. Element #3: At an all staff inservice held 1/10/2012 the policy and procedure for abuse will be covered including: 1. Abuse Policy 2. Types of abuse 3. Step by step action to be taken if abuse is suspected. 4. Questiions/answers/discussion Any staff who fail to comply with the points of the inservice will be further disciplined as appropriate, up to and including termination. Element #4: At the monthly QA meetings, any reports of abuse or alleged abuse will be reviewed to be certain all proper protocols were followed including, but not limited to: 1. Providing immediate safety for residents 2. Removing threat/assessing resident 3. Reporting to the adminisrator 4. Complete investigation/interviews	

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	"The writer received a phone call from...the nurse on the 3rd floor that there was a preacher in the building and that he went into a resident's room that wasn't dressed. (Activity Aide #1) brought the res (Resident B) to the nurses station and ...seemed mad and told the res to tell nurses what happened and res stated 'I told him to get the h--- out of my room and he didn't and then I told him again.' Then (Activity Aide #1) stated he checked and that the preacher wasn't even supposed to be in the building until 6:30 p.m. The nurse also reported that the aides from the second floor were here saying...that (Activity Aide #1) was going all over the bldg (building) telling people and now it was going to be reported to the state. (CNA #4) phoned this writer and stated that the preacher was in the hall...she asked the nurse who the resident was...she stated it was (Resident B)...then she went to the door...and noticed she (Resident B) had only a shirt on..." A "Notice of Disciplinary Action: dated 10/23/11 and signed as completed by ADON #3 for Activity Aide #1 included, but was not limited to: "Employee's Name: (Activity Aide #1)...		5. All proper reporting to all appropriate parties. Any concerns will be immediately addressed by the administrator.	

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Reported AA (Activity Aide) brought resident to nrsg (nursing) station et (and) had her report 'Man in her rm (room) et she told him to get the h--- out X2 (twice). (Activity Aide #1) responded with 'I checked the schedule he's not supposed to be in her till 6:30...(Activity Aide #1) then to 2nd floor stating it would be a reportable to state..."

During an interview with the Administrator on 12/07/11 at 3:00 p.m. he indicated Activity Aide #1 "walks a fine line" about discussing inappropriate material in groups including female residents and that he sometimes has to "reign him in." He also indicated that "sometime recently" (date uncertain) that LPN #5 had reported to him what she believed was an incident of resident verbal abuse. She indicated Activity Aide #1 was leading an activity group in the 3rd floor dining with approximately 10 residents in attendance, "mostly female" and that some topics discussed, including homosexuality and related activities, may have been inappropriate and potentially distressing to some residents present.

LPN #5 was interviewed on 12/07/11 at 3:20 p.m. She indicated that she had been working at the 3rd floor nurse's station and heard Activity Aide #1 leading a

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	group discussion, and that the topics of discussion were in her opinion inappropriate, including homosexuality and sexual activities. She indicated she was concerned that some topics of discussion may have been offensive or threatening to some residents present and that they may have had fear or anxiety as a result. She also indicated she had presented her concerns directly to the Administrator on the day it occurred but that she had not been advised of any follow up investigation or interventions. A facility "Notice of Disciplinary Action" dated 10/07/11 for Activity Aide #1 indicated "...Inappropriate material, shared with others. Questionable topic covered in group discussions." During an interview with the Administrator on 12/12/11 at 2:40 p.m. he indicated that the above incidents had been reported to him as documented. He indicated he gave consideration to each incident, and decided the allegations did not merit reporting to the State Agency. He also indicated he had investigated the incidents, but had no documentation of any investigation, including but not limited to identifying potentially affected residents, interviewing residents to determine if Activity Aide #1 had a history of verbal abuse or other concerns, or interviewing staff members to establish			

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	if there was a pattern of verbally abusive behavior by Activity Aide #1. He also indicated that the incident of 10/23/11 involving Resident B had not been reported to the State Agency and that he had not done a formal, documented investigation to determine if there was any potential risk to residents based on the allegations of this event. 2. An undated facility document titled "Abuse Protection and Response Policy" received from the Administrator on 12/07/11 at 3:00 p.m. and indicated to be the facility's current policy included, but was not limited to: "Policy: The center's administrator is responsible for assuring that patient safety, including freedom from risk of abuse, holds the highest priority...Reporting and Response Issues: Procedure: Any allegation of abuse will be reported immediately to the supervisor and administrator. Any investigation that substantiates abuse or neglect al alleged abuse or neglect findings will be reported immediately to the Administrator his/her designated representative and to other officials in accordance with State Law within 24 hours of the event. 3.1-28(a)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE